UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF WEST VIRGINIA

IN RE: DIGITEK®
PRODUCT LIABILITY LITIGATION

Master Docket No.

MDL No. 1968

PLAINTIFF: _____
(name)

DIGITEK® PLAINTIFF FACT SHEET

Please provide the following information for each individual on whose behalf a claim is being made. Please answer every question to the best of your knowledge. In completing this Fact Sheet, you are under oath and must provide information that is true and correct to the best of your knowledge. If you cannot recall all of the details requested, please provide as much information as you can. You must supplement your responses if you learn that they are incomplete or incorrect in any material respect. If you are completing the Fact Sheet for someone who has died or who cannot complete the Fact Sheet him/herself, please answer as completely as you can for that person.

The Fact Sheet shall be completed in accordance with the requirements and guidelines set forth in the applicable Case Management Order. A completed Fact Sheet shall be considered interrogatory answers pursuant to Fed. R. Civ. P. 33, as responses to requests for production pursuant to Fed. R. Civ. P. 34, and will be governed by the standards applicable to written discovery under Fed. R. Civ. P. 26 through 37. The questions and requests for production contained in the Fact Sheet are non-objectionable and shall be answered without objection.

In filling out this form, please use the following definition: "healthcare provider" means any hospital, clinic, center, physician's office, infirmary, medical or diagnostic laboratory, or other facility that provides medical care or advice, and any pharmacy, x-ray department, radiology department, laboratory, physical therapist or physical therapy department, rehabilitation specialist, chiropractor, or other persons or entities involved in the diagnosis, care and/or treatment of you.

In addition, to the extent that the Fact Sheet does not provide enough space to complete your responses or answers, please attach additional sheets as necessary.

I. CASE INFORMATION

1. Please state the following for the civil action that you filed:

   a. Case caption:_____

   b. Civil Action Number:_____

   c. Court in which action was originally filed:_____

d. Your attorney:

Name: _____

Address: _____

_____

2. Name of person completing this form: _____

3. Please list any other names you have used or by which you have been known and dates you used those names:

_____

4. Your current address: _____

_____

5. If you are completing this Fact Sheet in a representative capacity (e.g., on behalf of the estate of a deceased person or a minor), please complete the following:

a. Describe the capacity in which you are representing the individual or estate:

_____

b. If you were appointed as a representative by a court, state the:

Court which appointed you: _____

Date of Appointment: _____

c. What is your relationship to the individual you represent: _____

_____

d. If you represent a decedent's estate, state:

Decedent's date of death: _____

Address of place where decedent died: _____

_____

e. If you are claiming the wrongful death of a family member, identify any and all family members, beneficiaries, heirs or next of kin of that person, including their relationship to Decedent:

_____

_____

_____

THE REST OF THIS FACT SHEET REQUESTS INFORMATION ABOUT THE PERSON WHO PURCHASED, OR PURCHASED AND USED DIGITEK®. WHETHER YOU ARE COMPLETING THIS FACT SHEET FOR YOURSELF OR FOR SOMEONE ELSE, PLEASE ASSUME THAT "YOU" MEANS THE DIGITEK® PURCHASER OR PURCHASER AND USER.

II. CLAIM INFORMATION

1. Name of Digitek® Purchaser/User:_____

2. Have you used any other names in the last five (5) years? **Yes** ____ **No** ____

   If **yes**, please list any such names that you have used:

   _____

3. Do you claim that you suffered bodily injuries as a result of taking Digitek®?

   Yes ___ **No** ___ If **Yes**, please answer the following:

   a. What bodily injuries do you claim resulted from your use of Digitek®?

   _____

   _____

   b. When is the first time you saw a health care provider for any of the symptoms you link to your alleged injury?_____

   c. Are you currently experiencing symptoms related to your alleged injury?

   Yes ___ **No** ___ If **Yes**, please describe the symptoms:_____

   _____

   d. Did you see a doctor, clinic or healthcare provider for the bodily injuries or illnesses listed above?

   Yes ___ **No** ___ If **Yes**, who:_____

   _____

   e. Who diagnosed your injury?_____

   f. Date of diagnosis:_____

   g. Were you hospitalized?

   Yes ___ **No** ___ If **Yes**, please answer the following:

   1) Date of hospital admission:_____

2) Date of discharge:_____

3) Hospital name and address:_____

_____

h. What harm or consequence including physical limitations, do you claim you suffered as a result of the bodily injury above, excluding any mental or emotional damages, lost wages or out of pocket expenses listed below?

_____

_____

_____

i. Do you claim that your injury was caused by ingesting defective Digitek® medication?

Yes ___ **No** ___ If **Yes**, please answer the following:

1) Describe in detail what you claim the defect to have been in the Digitek® medication that you ingested:_____

_____

_____

2) How much of the defective product did you ingest?_____

3) When did you ingest the product?_____

j. Have you any discussions with any doctor or other healthcare provider about whether Digitek® caused you to suffer any illness or injury?

Yes ___ **No** ___ If **Yes**, who:_____

_____

4. Are you claiming mental and/or emotional damages as a result of taking Digitek®?

Yes___ **No** ____

If **Yes**, what mental and/or emotional damages do you claim resulted from your use of Digitek®?

_____

_____

If **Yes**, for each provider (including but not limited to primary care physicians, psychiatrists, psychologists, and/or counselors) from whom you have sought treatment for psychological, psychiatric or emotional problems, state the following:

NAME	ADDRESS	CONDITION TREATED	DATES TREATED	MEDICATIONS PRESCRIBED

5. Are you making a claim for lost wages or lost earning capacity?

Yes___ **No** ____ If **Yes**, state the annual gross income you derived from your employment for each of the last five (5) years:

_____

_____

_____

6. Have you incurred any out-of-pocket expenses as a result of using Digitek®?

Yes___ **No** ____ If **Yes**, please identify and itemize all out-of-pocket expenses you have incurred: _____

_____

7. What other damages, if any, do you claim you suffered as a result of the purchase or ingestion of Digitek®?

_____

_____

_____

III. DIGITEK® PRESCRIPTION INFORMATION

1. Have you ever used Digitek®? **Yes___ No ____**

2. If you answered **yes** to No. 1, identify the following for each period of time during which you took Digitek®:

DOSAGE (.125 MG OR .250 MG)	HOW OFTEN PER DAY OR WEEK?	DATE STARTED	DATE STOPPED	NAME OF PRESCRIBER

3. State the name(s) and address(es) of the pharmacies where Digitek® prescriptions were filled:_____

_____

_____

4. Identify the condition for which you were prescribed Digitek®:_____

_____

5. Did you receive any free samples of Digitek®?

Yes __ No __ If **Yes**, please state the following:

a. Who provided the samples? _____

b. When were samples provided? _____

c. What was the dosage of the samples? _____

d. How many samples were provided? _____

6. Do you have in your possession or does your attorney have the packaging from the Digitek® you allegedly purchased, or purchased and used, and/or any Digitek® tablets?

Yes ____ No____

a. If yes, who currently has custody of the Digitek® packaging and/or tablets?

_____

_____

_____

b. If you or your attorney is in possession of tablets, how many do you have? _____

c. Have you or anyone on your behalf tested the Digitek® tablets in your possession?

Yes ____ No____ If **Yes,**

1) Who tested the tablets?_____

2) What test(s) was performed?_____

_____

3) How many tablets were tested?_____

4) When were the tests performed?_____

5) What were the test results?_____

_____

(NOTE: In lieu of answering the following Question Nos. 7a and 7b, please attach a clear copy of the product packaging and/or the label on the vial or blister pack of Digitek® in your or your attorney's possession that provides the information sought below.)

7a. Do you know the lot number(s) for any of the Digitek® you received?

Yes ____ No____

If **Yes**, what is/are the lot number(s): _____

7b. Do you know the expiration date for any of the Digitek® you received?

Yes ____ No____

If **Yes**, when is/was/were the expiration date(s): _____

8. Have you had any communication, oral or written, with any of the defendants or their representatives?

Yes ____ No____

If **Yes**, set forth the date of the communication, the method of communication, the name of the person with whom you communicated, and the substance of the communication between you and any defendants or their representatives:

_____

9. Have you ever used any other digoxin or digitalis product (i.e. Lanoxin)?

Yes____ No____

If **Yes,** please state:

DOSAGE (.125 MG OR .250 MG)	HOW OFTEN PER DAY OR WEEK?	DATE STARTED	DATE STOPPED	NAME OF PRESCRIBER

10. Are you aware that Digitek® was recalled?

Yes___ **No** ____ If **Yes**, please state the following:

a. When you became aware of the recall:_____

b. How you became aware of the recall:_____

_____

11. Did you discuss the recall with any healthcare provider or pharmacist?

Yes___ **No** ____ If **Yes**, please state the following:

a. When that discussion occurred:_____

b. With whom:_____

12. Did you return any Digitek® to Stericycle or any pharmacy?

Yes _____ No_____ If **Yes,** please state the following:

a. When did you return the product?_____

b. Do you have your paperwork regarding the return? **Yes _____ No _____**

c. To whom did you return the product?_____

13. Have you ever visited a website, chat-room, message board or other electronic forum containing information or discussion about Digitek®?

Yes___ **No** ____ If **Yes**, please provide the name of the website:_____

IV. MEDICAL BACKGROUND

1. Current Height: _____

2. Current Weight: _____

3. Approximate weight at the time of your injury: _____

4. To the best of your knowledge, have you, or any blood-relative family member (child, parent, brother, sister, or grandparent), ever experienced or been diagnosed with any of the following conditions? Please select **Yes** or **No** for each condition. For each condition for which you answer **Yes**, please identify who suffered the condition, you or a relative, and please provide the relative's name and relationship to you. If you suffered the condition, please provide the additional information requested in the table following this chart:

CONDITION EXPERIENCED OR DIAGNOSED	YES	NO	WHO SUFFERED CONDITION
Abnormal heart rhythm, atrial fibrillation, atrial flutter, ventricular fibrillation, or heart block			
Alcoholism or other substance abuse			
Allergic reaction to medication (e.g., skin reaction, rash, or anaphylaxis)			
Alzheimer's, senility, confusion			
Arthritis (osteoarthritis or rheumatoid arthritis)			
Autoimmune diseases (e.g., rheumatoid arthritis, lupus, Sjogren's, etc.)			
Bleeding or clotting disorders			
Blocked or narrow arteries/plaque buildup/coronary artery disease			
Cancer			
Cardiomyopathy/enlarged heart			
Chest pain/angina			
Chronic obstructive pulmonary disease/COPD/chronic lung disease/asthma			
Congenital heart abnormality			
Congestive heart failure			
Deep vein thrombosis/DVT			
Depression, anxiety, schizophrenia, bipolar disorder			
Dermatologic diseases or conditions			
Diabetes mellitus			
Electrolyte imbalance			
Enlarged prostate, bladder dysfunction			
Gastrointestinal problems (e.g., ulcers, heartburn, acid reflux, GERD, increased or decreased motility)			
Hardening of the arteries/stenosis/aneurysms			

CONDITION EXPERIENCED OR DIAGNOSED	YES	NO	WHO SUFFERED CONDITION
Heart attack/MI/myocardial infarction			
Heart valve problems (e.g., murmur, leaky valve, prolapse, regurgitation)			
High blood pressure/hypertension			
High cholesterol or triglycerides			
Hormonal replacement therapy			
Hypothyroidism/Thyroid condition			
Immune system disease or dysfunction (including HIV or AIDS)			
Kidney disease or condition			
Liver disorder or disease (cirrhosis, hepatitis, etc.)			
Multiple sclerosis, myasthenia gravis			
Osteoporosis, bone fractures, calcium deficiency			
Peripheral vascular disease or peripheral arterial disease			
Pulmonary embolism/blood clot to the lungs			
Pulmonary hypertension			
Raynaud's syndrome/phenomenon			
Rheumatic Fever/Scarlet Fever			
Stroke/transient ischemic attack/TIA/aneurysm			
Tobacco use or addiction			
Vasculitis			

For each condition for which you answered **Yes** in the previous chart, please provide the information requested below:

CONDITION YOU EXPERIENCED	DATE OF ONSET	MEDICATION/ TREATMENT	TREATING PHYSICIAN AND/OR HOSPITAL

5. Please indicate whether you have ever been the subject of any **cardiovascular surgeries** including, but not limited to, open heart/bypass surgery, CABG, pacemaker or defibrillator implantation, stent placement, vascular surgery, angioplasty, IVC filter placement, carotid (neck) surgery, or valve replacement.

Yes ___ No __ I don't recall __ If **Yes**, please specify the following:

SURGERY	REASON FOR SURGERY	DATE	TREATING PHYSICIAN	HOSPITAL

6. Please indicate whether you have ever been the subject of any of the following **cardiovascular diagnostic tests** or interventions and provide the requested information about each, including, but not limited to: stress test C-reactive protein (CRP); chest X-ray; angiogram/catheterization; CT scan; MRI; EKG; echocardiogram; TEE (trans-esophageal echo); endoscopy; lung bronchoscopy; carotid duplex/ultrasound; MRI/MRA of the head/neck; angiogram of the head/neck; CT scan of the head; bubble/microbubble study; and Holter monitor.

Yes ___ No __ I don't recall __ If **Yes**, please specify the following:

DIAGNOSTIC TEST/ INTERVENTION	REASON FOR TEST/ INTERVENTION	DATE	TREATING PHYSICIAN/ HOSPITAL	RESULT OF DIAGNOSTIC TEST/ INTERVENTION

7. Do you now or have you ever smoked tobacco products? **Yes ___ No ___** If **Yes**, please specify the following:

a. How long have/did you smoke? _____

b. How much do/did you smoke? _____

8. Did you drink alcohol (beer, wine, etc.) in the three years before your alleged injury?

Yes ___ No ___ If **Yes**, please specify the following:

a. How often did you drink?_____

b. How much did you drink?_____

9. Have you ever used any illicit drugs of any kind within the five (5) years before, or at any time after, your alleged injury?

Yes ___ No ___ If **Yes**, identify the substance(s) and your first and last use:_____

_____

V. ADDITIONAL MEDICATIONS (INCLUDING OTHER DIGOXIN PRODUCTS, SUCH AS LANOXIN®)

1. For any medications, herbal products or supplements other than Digitek® that you took on a regular basis in the ten (10) years prior to, and at the time of, the incidents described in your Complaint, please provide the information requested below:

NAME OF MEDICATION USED	DOSAGE	PRESCRIBING PHYSICIAN	DATES OF USE	PURPOSE OF PRESCRIPTION

2. Have you ever experienced any side effects while you were taking any of the medications identified in this section in the past ten (10) years?

Yes ___ No ___ If **Yes**, please specify the following:

a. The name of the medication:_____

b. The side effect(s):_____

c. The date you experienced the side effect:_____

VI. PERSONAL INFORMATION

1. Current address and date when you began living at this address: _____

_____

2. Social Security Number: _____

3. Date and place of birth: _____

4. Marital Status: _____

If married, spouse's name, occupation and date of marriage: _____

_____

If divorced, dates of the marriage, case name/jurisdiction of the divorce: _____

_____

Has your spouse filed a loss of consortium in this action? **Yes ___ No ___**

5. If you have children, please list each child's name and date of birth:

_____

_____

_____

6. For any school attended after High School, please provide the following information:

a. School Name:_____

b. Address:_____

c. Dates attended:_____

d. Diploma/Degree:_____

7. Employment information for the last ten (10) years. Please include employer's name, address, dates of employment, job title, job description and duties:

_____

_____

8. Have you ever served in the military, including the military reserve or National Guard?

Yes ___ No ___

If **Yes**, were you ever rejected or discharged from military service for any reason relating to your physical condition? **Yes ___ No ___**

If **Yes**, state the condition for which you were rejected or discharged:_____

_____

9. Has any insurance or other company, or Medicare or Medicaid, provided medical coverage to you or paid medical bills on your behalf in the last ten (10) years?

Yes ___ No ___ If **Yes**, please specify the following:

a. The name of the company/agency:_____

b. Address:_____

c. Dates of Service:_____

10. Have you applied for workers' compensation (WC) and/or social security disability (SSI or SSD) benefits in the last ten (10) years?

Yes ___ No ___ If **Yes**, please specify the following:

a. Type of claim:_____

b. Year application filed:_____

c. Agency where application was filed:_____

d. Nature of disability:_____

e. Time period of disability:_____

11. Have you filed a lawsuit or made a claim in the last ten (10) years, other than in the present suit, relating to any bodily injury?

Yes ___ No ___ If **Yes**, please specify the following:

a. Court in which suit/claim filed or made:_____

b. Case/claim number:_____

c. Nature of claim/injury:_____

12. As an adult, have you been convicted of, or plead guilty to, a felony and/or crime of fraud or dishonesty?

Yes ___ No ___ If **Yes**, please set forth where, when and the felony and/or crime:_____

_____

VII. HEALTHCARE PROVIDERS AND PHARMACIES

1. Identify each doctor or other healthcare provider who you have seen for medical care and treatment in the past ten (10) years:

NAME AND SPECIALTY	ADDRESS	REASON FOR VISIT	APPROX DATES/YEARS OF VISITS

2. Identify each hospital, clinic, or healthcare facility where you were hospitalized (in-patient, out-patient, or emergency room visit) in the past ten (10) years:

NAME	ADDRESS	ADMISSION DATE(S)	REASON FOR ADMISSION

3. Identify each pharmacy that has dispensed medication to you in the past ten (10) years:

NAME OF PHARMACY	ADDRESS	APPROX DATES/YEARS YOU USED PHARMACY

VIII. DECEASED INDIVIDUALS AND AUTOPSY INFORMATION

1. If you are filling this out on behalf of an individual who is deceased, please state the following from the Death Certificate of the individual:

(NOTE: In lieu of the following, please attach a copy of the death certificate.)

Date of death: _____
Place of death (city, state and county): _____
Facility or location where death occurred: _____
Name of physician who signed death certificate: _____
Cause of death: _____

_____

If you are filling this out on behalf of an individual who is deceased and on whom an autopsy was performed, please fill in the information below pertaining to the autopsy and the autopsy report:

(**NOTE: In lieu of the following, please attach a copy of the autopsy report.)**

Date: _____
Performed by: _____
Facility where autopsy was performed: _____
Place where autopsy was performed (city, state, county): _____
Describe any and all tissue preserved: _____

IX. FACT WITNESSES

1. Please identify all persons you believe possess information concerning your injury(ies) and current medical conditions, other than your healthcare providers, and please state their names addresses and relationship to you:

Name: _____
Address: _____
_____
Relationship to you: _____

Name: _____
Address: _____
_____
Relationship to you: _____

Name: _____
Address: _____
_____
Relationship to you: _____

Name: _____
Address: _____
_____
Relationship to you: _____

Name: _____
Address: _____
_____
Relationship to you: _____

IX. DOCUMENT DEMANDS

1. Authorizations: please sign authorizations that are attached hereto as Exhibit A, for each of the healthcare providers you have identified above in your Answers to §II, Question Nos. 1-3, and § IV, Question No. 2.

2. Documents in your possession, including writings on paper or in electronic form: If you have any of the following materials in your custody or possession, please attach a copy to this Fact Sheet.

   a. All documents constituting, concerning or relating to product use instructions, product warnings, package inserts, pharmacy handouts or other materials distributed with or provided to you in connection with your use of Digitek®.

   b. Copies of the entire packaging, including the box and label, for Digitek® and any Digitek® tablets (plaintiffs or their counsel must maintain the originals of the items requested in this subpart).

   c. All documents relating to your purchase of Digitek®, including, but not limited to, receipts, prescriptions or records of purchase.

   d. All photographs, drawing, journals, slides, videos, DVDs or any other media relating to your alleged injuries.

   e. Copies of letters testamentary or letters of administration relating to your status as plaintiff (if applicable).

   f. Decedent's death certificate and autopsy report (if applicable).

   g. Medical records, bills, correspondence, reports and all other documents from any health care provider who saw, evaluated or treated Plaintiff/Decedent in the last five (5) years.

   h. All emergency responder, paramedic or EMT reports regarding Plaintiff/Decedent.

   i. Documents concerning any communication between Plaintiff/Decedent or Plaintiff/Decedent's attorneys or agents and the FDA or any Defendant regarding the events giving rise to the lawsuit or relating to Digitek® .

   j. Non-privileged documents, including any diaries, calendars or notes that record Plaintiff/Decedent's health, use of Digitek® or alleged injuries.

X. VERIFICATION

I declare under penalty of perjury that all of the information provided in this Plaintiff Fact Sheet is true and correct to the best of my knowledge. I have supplied all the documents requested in Part IX of this declaration, to the extent that such documents are in my possession, custody, or control, or in the possession, custody, or control of my lawyers, and supplied the authorizations attached to this declaration.

Further, I acknowledge that I have an obligation to supplement the above responses if I learn that they are in any material respects incomplete or incorrect.

Date: _____ _____

Signature

073021.000031.1037923.1

HIPAA COMPLIANT AUTHORIZATION FOR RELEASE OF INFORMATION PURSUANT TO 45 C.F.R. 164.508

Patient Name:

Identification: Date of Birth Date of Death Soc. Sec.
Parents Name/Previous Name(s)

Provider:
(Who is releasing the information)

Requestor:
(to whom the information will be provided)

Name Tucker Ellis & West LLP
Address 1150 Huntington Bldg.
925 Euclid Avenue
Cleveland, OH 55115-1414

Information Requested: I authorize the disclosure of all protected medical information, from the time period 1998 to present, in written or electronic form for the purpose of review and evaluation in connection with a legal claim. I expressly request that all covered entities under HIPAA identified above disclose full and completed protected health information, including, but not limited to, the following:

- All medical records, including, but not limited to: inpatient, outpatient & emergency room treatment; all clinical charts, reports, documents, correspondence, test results, statements, questionnaires/histories, office and doctor's handwritten notes; and records received from other physicians or health care providers;
- All laboratory, histology, cystology, pathology, radiology, CT Scan, MRI, echocardiogram & cardiac catheterization reports;
- All radiology films; myelograms; CT Scans; photographs; bone scans; pathology, cytology, histology, autopsy, immuno-histo-chemistry specimens;
- All pharmacy prescription records, including, but not limited to: NDC numbers and drug information handouts/monographs
- All billing records, including, but not limited to: all statements, itemized bills, and insurance records.
- All documents related to amendment of any record requested.

Purpose of Release: For the purpose of review and evaluation in connection with a legal claim.

This authorization expires when the following event occurs: the resolution of litigation. I understand that I may revoke this authorization at any time, except to the extent that action has already been taken in reliance upon it, by giving written notice to Tucker Ellis & West LLP. I understand that the covered entity to whom this authorization is directed may not condition treatment, payment, enrollment or eligibility benefits on whether or not I sign the authorization. This information, once it is released, may be re-disclosed by the recipient, and if re-disclosed, the information would no longer be protected by the federal privacy rule. Any facsimile, copy or photocopy of the authorization authorizes you to release the records requested herein.

Signature of Patient if 18 years of age or older_____ Date_____

Signature of Parent or Legal Representative_____ Date_____

Relationship to Patient, if not signed by Patient_____

SPECIFIC authorization for release of information protected by state or federal law In addition to the authorization and other provisions contained above, hereby incorporated by reference, I authorize: (i) the release of data and information to Tucker Ellis & West LLP; and (ii) Tucker Ellis & West LLP's re-disclosure of the data and information to its consultants, experts, agents, and/or other counsel; any and all data, notes, records, reports, and/or any other documents and information relating to:

X 1. Substance Abuse (Alcohol/Drug) X 2. Mental Health (includes psychological testing) X 3. HIV-related information (AIDS related testing)

This form does not authorize re-disclosure of medical information beyond the limits of this consent. Where information has been disclosed from records protected by federal law for alcohol/drug abuse records or by state law for mental health records, federal requirements (42 C.F.R. Part 2) and state requirements prohibit further disclosure without specific written consent of the patient, or as otherwise permitted by such law and/or regulations. A general authorization for the release of medical or other information is not sufficient for these purposes. Civil and/or criminal penalties may attach for unauthorized disclosure of alcohol/drug abuse or mental health information. Federal regulations state that any person who violates any provision of this law shall be fined not more than $500, in the case of a first offense, and not more than $5000 in the case of each subsequent offense. Drug Abuse Office and Treatment Act of 1972 (21 U.S.C. 1175); Comprehensive Alcohol Abuse Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (42 U.S.C. 4582).

Signature of Patient if 18 years of age or older_____ Date_____

Signature of Parent or Legal Representative_____ Date_____

Relationship to Patient, if not signed by Patient_____

HIPAA COMPLIANT AUTHORIZATION FOR RELEASE OF EMPLOYMENT INFORMATION

Employee Name:

Identification: Date of Birth: Soc. Sec:
Parents Name/Previous Name(s)

Provider:
(Who is releasing the information)

Requestor:
(to whom the information will be provided)

Name Tucker Ellis & West LLP
Address 1150 Huntington Bldg.
925 Euclid Avenue
Cleveland, OH 55115-1414

I authorize the disclosure of all protected information in any form (including oral, written and electronic) for the purpose of review and evaluation in connection with a legal claim. I expressly request that all entities identified above disclose full and completed protected employment information spanning the time period of 1998 to present, including, but not limited to, the following:

- All applications for employment, resumes, records of all positions held, job descriptions of positions held, payroll records, W-2 forms and W-4 forms, performance evaluations and reports, statements and reports of fellow employees, attendance records, worker's compensation files, disability records; records submitted in connection with any claims by all physicians, psychologists, psychiatrists, hospital and testing facilities, radiologists, and any and all other health care providers; records of any payments made; records of any litigation resulting from denials of coverage;
- All insurance records, claim forms, renewal records, questionnaires and records of payments made, all insurance policies, and employee benefit records certificates and benefit schedules regarding the insured's coverage, including supplemental coverages; health and physical examination records reviewed for underwriting purposes; questionnaires and records submitted in connection with the applications or renewals;
- All hospital, physician, clinic, infirmary, nurse, psychiatric, psychological and dental records; x-rays, test results, physical examination records and other medical records, medication records;
- All documents related to amendment of any record requested;
- All records pertaining to medical or disability claims, or work-related accidents including correspondence, accident reports, injury reports and incident reports;
- All pension records, disability benefit records, and all records regarding participation in company-sponsored health, dental, life and disability insurance plans; and
- Any other records concerning employment of the Employee named above.

Purpose of Release: For the purpose of review and evaluation in connection with a legal claim brought by _____.

This authorization is expires when the following event occurs: the resolution of litigation I understand that I may revoke this authorization at any time, except to the extent that action has already been taken in reliance upon it, by giving written notice to Tucker Ellis & West LLP. I understand that the covered entity to whom this authorization is directed may not condition treatment, payment, enrollment or eligibility benefits on whether or not I sign the authorization. This information, once it is released, may be re-disclosed by the recipient, and if re-disclosed, the information would no longer be protected by the federal privacy rule. Any facsimile, copy or photocopy of the authorization authorizes you to release the records requested herein.

Signature of Employee if 18 years of age or older_____Date_____

Signature of Legal Representative_____Date_____

Relationship to Employee, if not signed by Employee_____

I. AUTHORIZATION FOR RELEASE OF DISABILITY CLAIMS RECORDS

To: _____
Name

_____
Address

_____
City, State and Zip Code

This will authorize you to furnish copies of any and all records of disability claims of any sort, including, but not limited to, statements, applications, disclosures, correspondence, notes, settlements, agreements, contracts or other documents, for the time period of 1998 to the present, concerning:

Name:

whose date of birth is _____ and whose social security number is _____.

You are authorized to release the above records to the following representatives of defendants in the Digitek® litigation, who have agreed to pay reasonable charges made by you to supply copies of such records:

Name Tucker Ellis & West LLP
Address 1150 Huntington Bldg.
925 Euclid Avenue
Cleveland, OH 55115-1414

This authorization does not authorize you to disclose anything other than documents and records to anyone.

This authorization shall be considered as continuing in nature and is to be given full force and effect to release information of any of the foregoing learned or determined after the date hereof. It is expressly understood by the undersigned and you are authorized to accept a copy or photocopy of this authorization with the same validity as though the original had been presented to you.

Date: _____ _____
Claimant/Guardian/Personal Representative Signature

HIPAA COMPLIANT AUTHORIZATION FOR RELEASE OF INSURANCE RECORDS

To:

Insured Name:
Date of Birth:
Soc. Sec. No.:

Requesting Attorneys: Tucker Ellis & West LLP
1150 Huntington Bldg.
925 Euclid Avenue
Cleveland, OH 55115-1414

I hereby authorize all insurers of _____, to disclose all insurance information from the time period of 1998 to present, including protected medical and mental health records, to and for the use of the law firm of Tucker Ellis & West LLP and any of their agents, consultants or designees. By way of example, the insurance information includes, but is not limited to, the following:

> All applications for insurance coverage and renewals; insurance policies, certificates and benefit schedules regarding the insured's coverage, including supplemental coverage; health and physical examination records that were reviewed for underwriting purposes, and any statements, communications, correspondence, reports, questionnaires, and records submitted in connection with applications or renewals for insurance coverage, or claims; physician, hospital, psychiatric, psychological, and dental reports, prescriptions, correspondence, test results, radiological films and any other medical records submitted for claims review purposes; claim records; records of all litigation; and all other records of any kind concerning or pertaining to _____.

The purpose of this authorization is for the review and evaluation of the information in connection with the Digitek® litigation.

I understand that the information is confidential and is accorded specific protection by federal and/or state laws and regulations. By signing this authorization, I consent to the disclosure to and use by the recipients of all protected information. I understand that, except as otherwise stated in this authorization, information disclosed pursuant to this authorization may be subject to redisclosure by the recipients and may no longer be protected by privacy laws and regulations.

I understand that certain records may be protected by federal or state law, including HIV, psychiatric or mental health treatment, alcohol/drug treatment or communicable diseases, and I am requesting that any and all such protected records be released under this authorization. Federal and/or state confidentiality rules prohibit the redisclosure of such protected records unless redisclosure is expressly permitted by the written consent of the person who is the subject of the information. A general authorization for the release of medical or other information is not sufficient for this purpose.

I understand that I may inspect or copy the protected health information sought to be used or disclosed in this authorization. I also understand that I am not required to sign this authorization and may in fact refuse to sign this authorization.

HIPAA COMPLIANT AUTHORIZATION FOR RELEASE OF INSURANCE RECORDS
Page 2

You are hereby released from any and all liability in connection with disclosure of records, documents, writings and physical evidence to the above firms.

This authorization is effective for one year from this date, or when the following event occurs: Final resolution of the above-identified civil action. Notwithstanding the immediately preceding sentence, I understand that I may revoke this authorization at any time prior to its expiration, except to the extent that action already has been taken in reliance on this authorization, by sending written notice of revocation to Shook, Hardy & Bacon LLP. I understand that the entity to whom this authorization is directed, may not condition treatment, payment, enrollment or eligibility benefits on whether or not I sign the authorization.

A copy of this authorization shall have the same force and effect as the original.

_____ _____

Signature of Insured or Insured's Representative — Date

Name of Insured:

_____

Former/Alias/Maiden Name of Insured

_____

Insured's Date of Birth

_____

Insured's Social Security Number

_____

_____

Insured's Address

_____ _____

Name of Insured's Representative (if applicable) — Description of Authority to Act for Insured